PAYMENT ERROR RATE MEASUREMENT (PERM)

Virginia has been selected as one of 17 states to participate in the Federal implementation of the Payment Error Rate Measurement (PERM) regulations during 2006. The Improper Payments Information Act (IPIA) of 2002 directs Federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to annually review its programs that are susceptible to significant erroneous payments and report the improper payment estimates to Congress. OMB identified the Medicaid and the State Children's Health Insurance Program (SCHIP) as programs at risk for significant erroneous payments. The PERM regulation at 42 CFR §431.950 through §431.1002 (published in the *Federal Register* on October 5, 2005, page 58276), directs the states to work with CMS in developing a national payment error rate to comply with the IPIA. The Department of Medical Assistance Service (DMAS) will work closely with the Centers for Medicare and Medicaid Services (CMS) and their partners to support this federal project.

The model can be summed up as follows: a statistically valid, random sample of adjudicated claims will be selected and reviewed to determine the validity of the payments made. The audit will include an examination of the accuracy of the claims processing system and the medical necessity of the service for which payment was claimed. The dollar amount of any errors identified (underpayments and overpayments) will be tracked and used to calculate the final payment error rate for Virginia and become part of the national error rate for 2006.

For the first year of the program, CMS will use three national contractors to measure the accuracy of Medicaid fee for service payments made for services rendered to recipients.

- The Lewin Group will provide statistical support to the program by producing the claims to be reviewed and by calculating Virginia's error rate.
- Livanta LLC will provide the documentation/database support by collecting medical policies from the State and by collecting medical records from providers.
- A review contractor will be engaged in spring 2006 to examine the accuracy of the claims processing system and the medical necessity of the service for which payment was claimed.

Only a small number of the more than 35,000 Medicaid providers will be asked to participate in this project over the next year. The total sample of about 1000 claims will be identified quarterly from claims paid October 1, 2005 through September 30, 2006. The Lewin Group is currently preparing the sample for the first quarter (October through December 2005) and will forward the list of approximately 250 claims to both DMAS and Livanta LLC. DMAS plans to notify

providers who have been selected to expect a documentation request from Livanta LLC to support the medical review of the claim. The first medical record requests are expected to be mailed out in April 2006.

Understandably, providers are concerned with maintaining the privacy of patient information. However, providers are required by Section 1902(a)(27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information, including medical records, regarding any payments claimed by the provider for rendering services. In addition, the collection and review of protected health information contained in individual-level medical records for payment review purposes is permissible by the Health Insurance Portability and Accountability Act of 1996 and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164. Therefore, no special patient permission is necessary for the release of records.

For each sampled claim, Livanta LLC plans to contact the provider to verify the correct name and address information and to determine how the provider wants to receive the request(s) (facsimile or U.S. mail) for medical records. Once the provider receives the documentation request, s/he must submit the information electronically or in hard copy within 90 days. Livanta LLC and possibly State officials will follow up to ensure that providers submit the documentation before the 90-day timeframe has expired so that the Virginia Medicaid Program is fully credited for claims accurately paid. If Livanta LLC requests medical records from you and you have questions, you may call Robin Reed at Livanta LLC at (301) 957-2380.

Past studies have shown that the largest cause of errors in the medical reviews results from no documentation or insufficient documentation. Therefore, information should be sent in timely and should be complete. If documentation is not provided, the amount of the claim will be considered an error, resulting in a higher error rate for DMAS and ultimately contributing to a higher error rate for Medicaid nationally.

One of the goals of this new program is to identify claims processing programs and medical policies that may contribute to increased payment errors. DMAS will work on corrective action plans to resolve any errors identified to ensure the most accurate payment rate possible.

As new information becomes available regarding the PERM program throughout the year, DMAS will provide updated information on the agency website.

42 CFR Part 457

Administrative practice and procedure, Grant programs-health, Health insurance, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINSTRATION

■ 1. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 2. Part 431 is amended by adding new subpart Q to read as set forth below:

Subpart Q—Requirements for Estimating Improper Payments in Medicaid and SCHIP

Sec.
431.950 Purpose.
431.954 Basis and scope.
431.958 Definitions and use of terms.
431.970 Information submission requirements.
431.1002 Recoveries.

Subpart Q—Requirements for Estimating Improper Payments in Medicaid and SCHIP

§ 431.950 Purpose.

This subpart requires States to submit information necessary to enable the Secretary to produce a national improper payment estimate for Medicaid and the State Children's Health Insurance Program (SCHIP).

§ 431.954 Basis and scope.

(a) *Basis.* The statutory bases for this subpart are sections 1102, 1902(a)(6), and 2107(b)(1) of the Act, which contain the Secretary's general rulemaking authority and obligate States to provide information, as the Secretary may require, to monitor program performance. In addition, this rule supports the Improper Payments Information Act of 2002, (Pub. L. 107–300) which requires Federal agencies to annually review and identify those programs and activities that may be susceptible to significant erroneous payments, estimate the amount of improper payments, and report those estimates to the Congress and, submit a report on actions the agency is taking to reduce erroneous payments. Section 1902(a)(27) of the Act requires providers to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish the Secretary with information regarding any payments claimed by the provider for furnishing services, as the Secretary may request.

(b) *Scope.* This subpart requires States under the statutory provisions in paragraph (a) of this section to submit Medicaid and SCHIP expenditures and claims data, medical policies, data processing manuals and other information as necessary for, among other purposes, estimating improper payments in Medicaid and SCHIP. This subpart also requires States to submit corrective action reports as prescribed by the Secretary for purposes of reducing their payment error rates. This subpart also requires providers to submit medical records and other information necessary to disclose the extent of services provided to individuals receiving assistance and furnish the information regarding any payments claimed by the provider for furnishing the services, to the Secretary as requested.

§ 431.958 Definitions and use of terms.

As used in this subpart, the following definitions apply:

Improper payment means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible recipient, any duplicate payment, any payment for services not received, any payment incorrectly denied and any payment that does not account for credits or applicable discounts.

Payment means any payment to a provider, insurer, or managed care organization for a Medicaid or SCHIP recipient for which there is Medicaid or SCHIP Federal financial participation. It may also mean a direct payment to a Medicaid or SCHIP recipient in limited circumstances permitted by CMS regulation or policy.

Payment error rate means an annual estimate of improper payments made under Medicaid and SCHIP equal to the sum of the overpayments (including payments to ineligible recipients) and underpayments, that is, the absolute value, expressed as a percentage of total payments made over the sampling period.

§ 431.970 Information submission requirements.

States must submit information to the Secretary for, among other purposes, estimating improper payments in Medicaid and SCHIP, that include but are not limited to—

(a) Claims data and annual expenditures from previous year;

(b) Quarterly, stratified adjudicated claims data from the review year;

(c) All medical and other policies in effect and quarterly updates as needed to perform claims reviews;

(d) Data processing systems manuals;

(e) Current provider contact information that is verified and/or updated to contain current provider contact information;

(f) Repricing information for claims that are determined to be improperly paid;

(g) Other information that the Secretary determines is necessary for, among other purposes, estimating improper payments and determining error rates in Medicaid and SCHIP, and

(h) A corrective action report as prescribed by the Secretary for purposes of reducing the payment error rate.

§ 431.1002 Recoveries.

States must return to CMS the Federal share of overpayments identified within 60 days in accordance with section 1903(d)(2) of the Act and related regulations at part 433, subpart F of this chapter. Payments based on erroneous Medicaid eligibility determinations are exempt from this provision because they are addressed under section 1903(u) of the Act and related regulations at part 431, subpart P of this chapter.

SUBCHAPTER D—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

PART 457—ALLOTMENTS AND GRANTS TO STATES

■ 3. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart G—Strategic Planning, Reporting, and Evaluation

■ 4. Section 457.720 is revised to read as follows:

§ 457.720 State plan requirement: State assurance regarding data collection, records, and report.

A State plan must include an assurance that the State collects data, maintains records, and furnishes reports to the Secretary, at the times and in the standardized format the Secretary may require to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under title XXI. This includes collection of data and reporting as required under § 431.970 of this chapter.